EMPLOYEE ASSISTANCE PROGRAM MANAGEMENT REFERRAL FORM

To initiate a Management Referral please: 1) First call 1-800-243-5240 for a consultation,
2) Second, immediately after the consultation, fax completed form to 1-888-892-8832

Horizon Health EAP Services
Organizational Risk Management Center
990 S. Broadway, #150
Denver, CO 80209

MRC 800-327-2287

Company Name: _____ Location: _____

Department: _____ Phone: ( ) _____

Referring Party: _____ Title: _____

Client Referred: _____ DOB: / /

Client's Phone: Work: ( ) _____ Home: ( ) _____

Client's Insurance: _____

Reason for Referral (complete or attach documentation describing reason/job performance issues):

_____

_____

Last Chance Agreement: (attach if written) Yes ☐ No ☐ Deadline Employee Must Call for Appt: / /

To the Employee: By signing this form, you are allowing Horizon Health EAP Services to release the following information:

Scope of Release: ☐ Alcohol/Drug Evaluation/Treatment ☐ Attendance ☐ Recommendations/Follow Through ☐ Compliance

To the following person(s):

_____ Name _____ Title ( ) _____ Phone

_____ Name _____ Title ( ) _____ Phone

Relation of above person(s) to client: _____

Purpose of releasing information: ☐ To track compliance with treatment recommendations

☐ Other (please specify) _____

This release expires on the following date: / / (1 year or less per HIPAA)

AUTHORIZATION

Your rights:

- You may revoke this Authorization at any time by submitting a written revocation to Horizon Health EAP at the address at the top of this page.
- A revocation will not apply to information that has already been used or disclosed in reliance on this Authorization.
- Once information is disclosed pursuant to this Authorization, it may be redisclosed by the recipient and the information will no longer be protected by HIPAA. (This would apply only if the party to whom the recipient disclosed personal health information is not subject to HIPAA privacy rules.)
- The plan may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- You will be provided with a copy of this Authorization form upon completion and execution.

_____ Signature of Referring Party _____ Date _____ Signature of Employee _____ Date